		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034256

Facility Name: MASON CITY AREA NURSING HOME

Address: 520 N. PRICE AVENUE (Number) MASON CITY (City) 62664 (Zip Code)

County: MASON

Telephone Number: (217) 482-5022 **Fax #** ( )

IDPA ID Number: 371168043001

Date of Initial License for Current Owners: 02/16/89

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Joyce Conrady

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) CRAIG L. ATER

(Firm Name & Address) Heritage Enterprises

(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	33	Skilled (SNF)	33	12,045	1
2		Skilled Pediatric (SNF/PED)			2
3	33	Intermediate (ICF)	33	12,045	3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	31		5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	24,090	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,414	4,450	1,344	18,208	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	5,571	0	5,571	12
13	DD 16 OR LESS					13
14	TOTALS	12,414	10,021	1,344	23,779	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.71%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? ____

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [XX]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 1,344

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Print Preview

	G/L	RECAP CENSUS	DIFF
PP	14713	14713	0
IPA	12426	12426	0
medicare	1344	1344	0
	28483	28483	

IPA BEDHOLDS	12
PP BEDHOLDS	273
PP CONVERS	4419

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	178,749	11,855	0	190,604		190,604	0	190,604			1
2	Food Purchase		117,047		117,047		117,047	(620)	116,427			2
3	Housekeeping	54,613	14,599		69,212		69,212	0	69,212			3
4	Laundry	33,652	6,105		39,757		39,757	0	39,757			4
5	Heat and Other Utilities			56,941	56,941		56,941	0	56,941			5
6	Maintenance	58,115	25,690	24,060	107,865		107,865	0	107,865			6
7	Other (specify):*							0				7
8	**TOTAL General Services**	325,129	175,296	81,001	581,426		581,426	(620)	580,806			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000	0	9,000			9
10	Nursing and Medical Records	968,498	63,134	14,778	1,046,410		1,046,410	0	1,046,410			10
10a	Therapy		35,487	83,347	118,834	(39,655)	79,179	0	79,179			10a
11	Activities	40,468	1,183	1,480	43,131		43,131	0	43,131			11
12	Social Services	20,014	42	1,367	21,423		21,423	0	21,423			12
13	Nurse Aide Training	0	0					0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16		1,028,980	99,846	109,972	1,238,798	(39,655)	1,199,143		1,199,143			16
	C. General Administration											
17	Administrative	57,110			57,110		57,110	0	57,110			17
18	Directors Fees							0				18
19	Professional Services			108,769	108,769		108,769	(75)	108,694			19
20	Dues, Fees, Subscriptions & Promotions			52,878	52,878	(36,135)	16,743	(5,338)	11,405			20
21	Clerical & General Office Expenses	99,608	11,108	14,343	125,059		125,059	0	125,059			21
22	Employee Benefits & Payroll Taxes			246,954	246,954		246,954	0	246,954			22
23	Inservice Training & Education			9	9		9	0	9			23
24	Travel and Seminar			5,611	5,611		5,611	(3,612)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			48,606	48,606		48,606	0	48,606			26
27	Other (specify):*			0				0				27
28	**TOTAL General Administration**	156,718	11,108	477,170	644,996	(36,135)	608,861	(9,025)	599,836			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,510,827	286,250	668,143	2,465,220	(75,790)	2,389,430	(9,645)	2,379,785			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			109,038	109,038		109,038	(1,060)	107,978			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			278	278		278	(278)				32
33	Real Estate Taxes			0				0				33
34	Rent-Facility & Grounds							(261)	(261)			34
35	Rent-Equipment & Vehicles			1,637	1,637		1,637	(812)	825			35
36	Other (specify):*							0				36
37	TOTAL Ownership			110,953	110,953		110,953	(2,411)	108,542			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					39,655	39,655	0	39,655			39
40	Barber and Beauty Shops	0	696	11,741	12,437		12,437	0	12,437			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					36,135	36,135	0	36,135			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		696	11,741	12,437	75,790	88,227		88,227			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,510,827	286,946	790,837	2,588,610	0	2,588,610	(12,056)	2,576,554			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(812)	35		5
6	Rented Facility Space	(261)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,060)	30		9
10	Interest and Other Investment Income	(278)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(620)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties				18
19	Entertainment	(3,612)	24		19
20	Contributions	0	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(75)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(5,338)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (12,056)		$	30

OHF USE ONLY									
48		49		50		51		52	

Print Preview

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (12,056)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **MASON CITY AREA NURSING HOME**

ID# **0034256**

Report Period Beginning: **1/01/01**

Ending: **12/31/01**

Print Other Adjustments

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	(620)
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	0	0	Line 4	0
5	Telephone, TV & Radio in Resident Rooms	(812)	35	Line 5	0
6	Rented Facility Space	(261)	34	Line 6	0
7	Sale of Supplies to Non-Patients	0		Line 7	0
8	Laundry for Non-Patients	0		Line 8	(620)
9	Non-Straightline Depreciation	(1,060)	30	Line 9	0
10	Interest and Other Investment Income	(278)	32	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0		Line 10a	0
12	Non-Working Officer's or Owner's Salary	0		Line 11	0
13	Sales Tax	(620)	2	Line 12	0
14	Non-Care Related Interest	0	32	Line 13	0
15	Non-Care Related Owner's Transactions	0	33	Line 14	0
16	Personal Expenses (Including Transportation)	0	24	Line 15	0
17	Non-Care Related Fees	0	20	Line 16	0
18	Fines and Penalties	0		Line 17	0
19	Entertainment	(3,612)	24	Line 18	0
20	Contributions	0	27	Line 19	(75)
21	Owner or Key-Man Insurance	0		Line 20	(5,338)
22	Special Legal Fees & Legal Retainers	(75)	19	Line 21	0
23	Malpractice Insurance for Individuals	0		Line 22	0
24	Bad Debt	0	27	Line 23	0
25	Fund Raising, Advertising and Promotional	(5,338)	20	Line 24	(3,612)
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	0	0	Line 27	0
29	Non-Paid Workers	0	0	Line 28	(9,025)
30	Donated Goods	0	0	Line 29	(9,645)
31	Amortization Expense	0	0	Line 30	(1,060)
32				Line 31	0
33				Line 32	(278)
34				Line 33	0
35				Line 34	(261)
36				Line 35	(812)
37				Line 36	0
38				Line 37	(2,411)
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(12,056)

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(620)	0	0	0	0	0	0	0	0	0	0	(620)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(620)	0	0	0	0	0	0	0	0	0	0	(620)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(75)	0	0	0	0	0	0	0	0	0	0	(75)	19
20	Fees, Subscriptions & Promotions	(5,338)	0	0	0	0	0	0	0	0	0	0	(5,338)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,612)	0	0	0	0	0	0	0	0	0	0	(3,612)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,025)	0	0	0	0	0	0	0	0	0	0	(9,025)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,645)	0	0	0	0	0	0	0	0	0	0	(9,645)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(1,060)	0	0	0	0	0	0	0	0	0	0	(1,060)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(278)	0	0	0	0	0	0	0	0	0	0	(278)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(261)	0	0	0	0	0	0	0	0	0	0	(261)	34
35	Rent-Equipment & Vehicles	(812)	0	0	0	0	0	0	0	0	0	0	(812)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,411)	0	0	0	0	0	0	0	0	0	0	(2,411)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,056)	0	0	0	0	0	0	0	0	0	0	(12,056)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number MASON CITY AREA NURSING HOM # 0032456 Report Period Beginning: 1/01/01 Ending: 12/31/01

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

Sum_6

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10											0	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 0	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill t the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered comple and timely filed until this statement and the corresponding real estate tax bills are filed. If you have an

To Print this page only

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2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME _____ COUNTY _____

FACILITY IDPH LICENSE NUMBER _____

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0	$ 0

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land		02/16/89	$ 26,000	1
2				10,000	2
3	TOTALS			$ 36,000	3

Print Preview

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	97				$ 2,605,181	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1990 Improvements			1990	7,990						9
10	1991 Improvements			1991	16,512						10
11	1992 Improvements			1992	22,678						11
12	1993 Improvements			1993	0						12
13	1994 Improvements			1994	24,788						13
14	1995 Improvements			1995	17,777						14
15											15
16	Water Heater			1997	4,800						16
17	Asphalt Sealer			1997	5,395						17
18	Entrance & Walkway			1997	1,700						18
19	Landscaping			1997	6,770						19
20											20
21	Kitch Central A/C			1996	15,800						21
22	Central A/C Administrative Offices			1996	2,500						22
23	Landscapping			1996	2,710						23
24	Automatic Door Closers			1996	3,732						24
25											25
26	Life Safety Alarm			1998	992						26
27	Sound System Cafeteria			1998	1,442						27
28	Security System			1998	10,742						28
29											29
30	Parking Lot Paving			1999	4,190						30
31	Petroleum tank			1999	12,500						31
32											32
33											33
34	C/O Allocation										34
35	Book Depreciation					77,376		77,376		908,541	35
36											36

* Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for Total

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

0 Page 12B
0 Page 12C
0 Page 12D
0 Page 12E
0 Page 12F
0 Page 12G
0 Page 12H
0 Page 12I

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Firewalls---ceilling	2000	10,800						37
38	Facility Remodel--Materials (Carpeting)	2000	22,660						38
39									39
40	Wallpaper	2001	5,552						40
41	Carpet Installation	2001	4,141						41
42	Woodwork Refinishing	2001	418						42
43	Water Heater	2001	6,125						43
44	Facility Remodel--Labor	2001	1,520						44
45	Parking Lot	2001	9,375						45
46	Living room Remodel	2001	415						46
47	Facility Remodel--Materials	2001	23,795						47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62	Ceramic Tile Shower	2001	698						62
63	Hot Water Pump	2001	2,586						63
64	Carpeting and Installation	2001	2,208						64
65	Wander Guard	2001	1,270						65
66	Light Fixtures and Door	2001	2,777						66
67	Flooring	2001	1,311						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,863,850	$ 77,376		$ 77,376	$ 0	$ 908,541	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,863,850	$ 77,376		$ 77,376	$	$ 908,541	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,863,850	$ 77,376		$ 77,376	$ 0	$ 908,541	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,863,850	$ 77,376		$ 77,376	$	$ 908,541	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,863,850	$ 77,376		$ 77,376	$ 0	$ 908,541	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,863,850	$ 77,376		$ 77,376	$	$ 908,541	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,863,850	$ 77,376		$ 77,376	$ 0	$ 908,541	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

To Print this page only

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,863,850	$ 77,376		$ 77,376	$	$ 908,541	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,863,850	$ 77,376		$ 77,376	$ 0	$ 908,541	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

To Print this page only

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

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	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,863,850	$ 77,376		$ 77,376	$	$ 908,541	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,863,850	$ 77,376		$ 77,376	$ 0	$ 908,541	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

To Print this page only

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

Hold down Control Key and hit k

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,863,850	$ 77,376		$ 77,376	$	$ 908,541	1
2									2
3									3
4									4
5									5
6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,863,850	$ 77,376		$ 77,376	$ 0	$ 908,541	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

To Print this page only

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

Hold down Control Key and hit L

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,863,850	$ 77,376		$ 77,376	$	$ 908,541	1
2									2
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4									4
5									5
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,863,850	$ 77,376		$ 77,376	$ 0	$ 908,541	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

To Print this page only

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		2,863,850	77,376		77,376		908,541	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,863,850	$ 77,376		$ 77,376	$ 0	$ 908,541	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 414,744	$ 30,602	$ 30,602	$		$ 345,737	71
72	Current Year Purchases	28,704						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 443,448	$ 30,602	$ 30,602	$		$ 345,737	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,343,298	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 107,978	82
83	Straight Line Depreciation	(line 70, col.7 + line 75 ,col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 107,978	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,254,278	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 825 Description: pager, computer equipment, copier
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		0		
3	Classroom Wages (a)		0		
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$		$ 26,209	$		$ 26,209	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			6,405			6,405	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			46,565			46,565	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				35,487		35,487	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab / X-ray	39/3				4,168			4,168	13
14	TOTAL			$		$ 83,347	$ 35,487		$ 118,834	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 383,655	$	1
2	Cash-Patient Deposits	5,511		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	307,260		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,090		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	0		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 725,516	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,500		13
14	Buildings, at Historical Cost	2,946,742		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	443,448		16
17	Accumulated Depreciation (book methods)	(1,255,339)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	0		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,218,351	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,943,867	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 60,700	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,511		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	161,951		30
31	Accrued Taxes Payable (excluding real estate taxes)	477		31
32	Accrued Real Estate Taxes(Sch.IX-B)	0		32
33	Accrued Interest Payable	277		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 228,916	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	130,000		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 130,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 358,916	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,584,951	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,943,867	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,419,399	1
2	Restatements (describe):		2
3	audit Adjustment	(3,000)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,416,399	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	168,552	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 168,552	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,584,951	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,767,391	1
2	Discounts and Allowances for all Levels	(273,417)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,493,974	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	151,674	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 151,674	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	450	11
12	Gift and Coffee Shop	879	12
13	Barber and Beauty Care	14,891	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	261	16
17	Sale of Drugs	78,570	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	391	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 95,442	23
	D. Non-Operating Revenue		
24	Contributions	5,626	24
25	Interest and Other Investment Income***	10,446	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,072	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		0	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,757,162	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 581,426	31
32	Health Care	1,238,798	32
33	General Administration	644,996	33
	B. Capital Expense		
34	Ownership	110,953	34
	C. Ancillary Expense		
35	Special Cost Centers	12,437	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		0	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,588,610	40
41	**Income before Income Taxes (line 30 minus line 40)****	168,552	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 168,552	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,883	2,088	$ 49,427	$ 23.67	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	15,438	16,261	280,981	17.28	3
4	Licensed Practical Nurses	10,521	11,413	167,736	14.70	4
5	Nurse Aides & Orderlies	36,598	38,975	408,887	10.49	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,871	6,594	61,467	9.32	8
9	Activity Director					9
10	Activity Assistants	5,061	5,427	40,468	7.46	10
11	Social Service Workers	1,909	2,116	20,014	9.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,087	22,732	178,749	7.86	15
16	Dishwashers					16
17	Maintenance Workers	6,453	6,865	58,115	8.47	17
18	Housekeepers	7,813	8,407	54,613	6.50	18
19	Laundry	4,019	4,214	33,652	7.99	19
20	Administrator	2,080	2,080	57,110	27.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,900	7,434	99,608	13.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,633	134,606	$ 1,510,827 *	$ 11.22	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		9,000		36
37	Medical Records Consultant		300		37
38	Nurse Consultant				38
39	Pharmacist Consultant		0		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		0		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 9,300		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		13,638		52
53	TOTAL (lines 50 - 52)		$ 13,638		53

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joyce Conrady	Administrator		$ 57,110
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,110

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 96,000
Abbott & Co	Audit	4,600
CNA Trust	401K	1,848
Williams & McCarthy	401K	679
SMS Consulting	Consulting	5,567
Hartweg, Muller	legal	75
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 108,769

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,339
Unemployment Compensation Insurance	0
FICA Taxes	116,347
Employee Health Insurance	83,462
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	21,806
Employee Benefits - central office	
TOTAL (agree to Schedule V, line 22, col.8)	$ 246,954

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	4,333
Health Care Worker Background Check	
(Indicate # of checks performed)	330
Central Office Allocation	
Promotional Advertising	769
Public Relations	4,569
Dues and Subscriptions	5,702
License and Fees	1,040
Less: Public Relations Expense	(4,569)
Non-allowable advertising	(0)
Yellow page advertising	(769)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,405

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,216
	350
Seminar Expense	3,045
Non Allowable	(3,612)
Central Office Allocation	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **36,135**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **6,984**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **Not complete as of the filing date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount					
1009	PETTY CASH	383655							1009	1009 PETTY CAS	383,655	
1010	CASH IN BANK								1100	1100 ACCTS REC	307,260	
1040	CASH IN BANK-PAYROLL								1101	1101 ALLOW. FOR UNCOLLECTIBLES		
1100	ACCOUNTS RECEIVABLE	307260							1110	1110 ACCTS RECEIV-M/C		
1110	MEDICARE RECEIVABLES								1125	1125 ACCTS RECEIV-IPA		
1125	IPA INCOME RECEIVABLE								1135	1135 ACCTS RECEIV-IC		
1130	MEDICARE COST REPORT								1140	1140 UNAPPLIED CASH RECEIPTS		
1135	ACCOUNTS RECEIVABLE-IC								1145	1145 A/R SUSPENSE-REFUNDS		
1140	UNAPPLIED CASH RECEIPTS								1200	1200 PREPAID IN	29,090	
1145	A/R SUSPENSE-REFUNDS								1220	1220 OTHER PREPAID EXPENSES		
1190	ACCRUED INTEREST REC								1300	1300 DIETARY INVENTORY		
1200	PREPAID INSURANCE	29090							1310	1310 SUPPLIES INVENTORY		
1220	OTHER PREPAID EXPENSES								1320	1320 LINEN INVENTORY		
1300	FOOD INVENTORY								1409	1409 LAND	83500	
1310	SUPPLIES INVENTORY								1450	1450 FURNITUR	443,448	
1409	LAND	83500							1460		(345,737)	
1450	FURNITURE & EQUIPMENT	443448							1475	1475 CODE ALE	2946742	
1460	ACCUM DEPR-FURN & EQUIP	-345737							1490	1490 ACCUM DE	-909602	
1475	BUILDING & IMPROVEMENTS	2946742							1530	1530 RESIDENT	5511	
1490	ACCUM DEPR-BUILDING	-909602							1550	1550 LOAN FEES		
1530	RESIDENT FUNDS	5511							1551	1551 LOAN FEES ADDED		
1550	LOAN FEES	0							1850	1850 INTERCOMPANY		
1560	REAL ESTATE TAX ESCROW								2010	2010 ACCOUNTS	(60,700)	
1575	REIMBURSABLE PURCHASES								2100	2095 BONUSES PAYABLE		
1850	INTRACOMPANY	0							2100	2100 ACCRUED	-73153	
2010	ACCOUNTS PAYABLE	-60700							2100	2100 PR CLEARING-BENEFITS		
2095	BONUSES PAYABLE								2100	2100 PR CLEARING-LABOR		
2100	ACCRUED PAYROLL	-73153							2110	2110 ACCRUED	(88,798)	
2110	ACCRUED VACATION PAY	-88798							2120	2120 U.C. TAXES PAYABLE		
2120	UC TAXES PAYABLE								2125	2125 FICA TAXES PAYABLE		
2125	FICA TAX PAYABLE	-477	-477						2130	2130 FEDERAL W	(477)	
2130	FIT PAYABLE								2140	2140 STATE W/H TAX PAYABLE		
2140	STATE W/H PAYABLE		0						2152	2152 WORKERS COMP ACCRUAL		
2145	EARNED INCOME CREDIT								2225	2225 EMPLOYEEE INSURANCE REFUND		
2150	UC FED CREDIT REDUCTION								2230	2230 PAYROLL SAVINGS		
2230	PAYROLL SAVINGS								2235	2240 UNITED FUND		
2235	IRA W/HOLDINGS								2240	2246 GROUP INSURANCE - CAFETERIA		
2240	UNITED WAY								2246	2250 401K W/H		
2245	GROUP INSURANCE PAYABLE								2250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA								2260	2260 WAGE GARNISHMENT		
2260	WAGE GARNISHMENTS								2300	2300 ACCRUED	(277)	
2280	MISC PAYROLL DEDUCTIONS								2320	2320 IPA PAYMENTS PAYABLE		
2300	ACCRUED INTEREST PAYABLE	-277							2350	2350 REAL ESTATE TAXES PAYABLE		
2310	SALES TAX PAYABLE								2385			
2320	IPA PAYMENTS PAYABLE	0							2400	2400 CURRENT PORTION OF LT DEBT		
2350	REAL ESTATE TAX PAYABLE	0							2512	2512 DUE TO RE	-5511	
2385	ACTIVITY FUND	0							2600	2600 LASALLE B	-130000	
2390	SECURITY DEPOSITS								2600			
2391	VOLUNTEER FUND								2625	2625 LASALLE CONSTR. LOAN #2		
2393	HEART FUND/BAZAAR								2625			
2395	DEFERRED INC EMP & MEM								2695	2695 CURRENT PORTION OF LT DEBT		
2400	CURRENT PORTION LT DEBT								2720	2720 RETAINED	-2416399	
2460	INCOME TAXES PAYABLE									net income	-168552	
2512	DUE TO RESIDENTS	-5511									0	
2600	MORTGAGE PAYABLE	-130000										
2650	EQUIPMENT LOAN PAYABLE									balance	0	
2695	CURRENT PORTION LT DEBT											
2696	DEFERRED INCOME TAXES											
2710	COMMON STOCK											
2720	RETAINED EARNINGS	-2416399										
2970	PROFIT/LOSS FOR PERIOD	-168552										
3007.1	PATIENT DAYS-PRIVATE	14713							3007	3007 PATIENT D	14,713	
3007.2	PATIENT DAYS-IPA	12426							3007	3007 PATIENT D	12,426	
3007.3	PATIENT DAYS-MEDICARE	1344							3007	3007 PATIENT D	1,344	
3007.4	PATIENT DAYS-CONVERSION								3007			
3007.5	PATIENT DAYS-LICENSED								3007			
3007.6	PATIENT DAYS-TOTAL								3007			
3010	1 BASIC CHARGE-PRIVATE & VA	-1132931		0	0	0	0		3007			
3015	1 PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		3010	3010 BASIC CHA	(1,132,931)	
3020	1 BASIC CHARGE-IPA	-1034873		0	0	0	0		3020	3020 BASIC CHA	(1,034,873)	
3030	1 BASIC CHARGE-MEDICARE	-366502		0	0	0	0		3030	3030 BASIC CHA	(366,502)	
3035	4 DAY CARE/HOME CARE			0	0	0	0		3040	3040 LIGHT NUR	(12,249)	
3040	1 LIGHT NURSING CARE	-94088		0	0	0	0		3050	3050 MEDIUM N	(61,229)	
3050	1 MEDIUM NURSING CARE			0	0	0	0		3060	3060 HEAVY NU	(18,540)	
3060	1 HEAVY NURSING CARE			0	0	0	0		3061	3061 SKILLED N	(2,070)	
3061	1 SKILLED NURSING CARE								3080	3080 NURSING S	(24,933)	
3080	1 NURSING SUPPLIES-PRIVATE	-136050		0	0	0	0		3081	3081 NURSING S	(52,411)	
3081	1 NURSING SUPPLIES-IPA			0	0	0	0		3082	3082 NURSING S	(14,198)	
3082	1 NURSING SUPPLIES MED PT A			0	0	0	0		3083	3083 NURSING S	(44,508)	
3083	1 NURSING SUPPLIES MED PT B								3100	3100 DRUGS-ME	(78,570)	
3100	17 DRUGS	-78570		0	0	0	0		3101			
3101	17 DRUGS-OTHER								3110	3110 PHYSICAL	(9,226)	
3110	6 PT-PRIVATE	-151674		0	0	0	0		3111			
3111	6 PT-IPA			0	0	0	0		3112	3112 PHYSICAL	(60,400)	
3112	6 PT-MEDICARE PART A			0	0	0	0		3113	3113 PHYSICAL	(19,960)	
3113	6 PT-MEDICARE PART B			0	0	0	0		3140	3140 LABORATO	(6,078)	
3130	1 PUBLIC AID ASSESSMENT INC								3150	3150 ST/OT THE	(1,360)	
3140	19 LABORATORY INCOME			0	0	0	0		3151			
3150	6 SPEECH/OT-PRIVATE			0	0	0	0		3152	3152 ST/OT THE	(36,200)	
3151	6 SPEECH/OT-IPA			0	0	0	0		3153	3153 ST/OT THE	(9,600)	
3152	6 SPEECH/OT-MED PART A			0	0	0	0		3160	3160 X-RAY SER	(8,850)	
3153	6 SPEECH/OT MED PART B								3410	3410 IPA DISCO	51,593	
3410	2 IPA DISCOUNTS	273417		0	0	0	0		3411	3411 MEDICARE	2,386	
3411	2 MEDICAID PART B DISCOUNT			0	0	0	0		3420	3420 MEDICARE	219,438	
3420	2 MEDICARE DISCOUNTS			0	0	0	0		3500			
3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3520	3520 RENT INCO	-261	
3520	16 RENT INCOME	-261		6	0	6	-261		3530	3530 BEAUTY SH	(14,891)	
3530	13 BEAUTY SHOP	-14891		0	0	0	0		3560			
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0		3570	3570 VENDING I	(879)	
3570	12 VENDING INCOME/EXPENSE	-879		0	0	0	0		3590	3590 EQUIPMEN	(2,947)	
3580	12 MANAGEMENT FEES			0	0	0	0		3595			
3590	1 EQUIPMENT RENTAL	-2947		0	0	0	0		3600	3600 MISC INCO	(391)	-2740640
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0		4110	4110 G&A WAG	93,034	
3600	21 MISC INCOME	-391		0	0	0	0		4111	4111 ADMINIST	57,110	
4110	GENERAL & ADMINIST WAGES	93034	99608	21	1	17	0		4115	4115 G&A PTO &	6,574	
4111	ADMINISTRATOR WAGES	57110	57110	17	1	0	0		4120	4120 EMPLOYEE	22,628	
4115	VACATION & SICK - G&A	6574		21	1	0	0		4125			
4120 4475	EMPLOYEE BENEFITS	21806	246954	22	3	0	0		4130			
4125	EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0		4135			
4130	EMPLOYEE SCHOLORSHIP WAGE	0		21	1	0	0		4250	4250 OFFICE SU	5963	
4135	EMPLOYEE SCHOLORSHIP COST	0		23	3	0	0		4255	4255 POSTAGE	2,771	
4220	DIRECTORS FEES			18	3	0	0		4260	4260 TELEPHON	14,343	
4250 4255	OFFICE SUPPLIES	11108	11108	21	2	0	0		4275	4275 TRAINING	9	
4260	TELEPHONE	14343	14343	21	3	0	0		4276			
4275	TRAINING & EMPLOYEE DEVL	9	9	23	3	16	0	***	4280	4280 GENERAL T	2,216	
4280	GENERAL TRAVEL	2216	5611	24	3	16	0		4281	4281 MEAL EXP	350	
4281	MEAL EXPENSE FOR TRAVEL	350		24	3	19	0		4285	4285 EDUCATIO	2,854	
4285	EDUCATION & SEMINAR	3045		24	3	19	-3612	***	4289	4289 MEETINGS	191	
4290	HELP WANTED ADVERTISING	4333	52878	20	3	0	0	-36135	4290	4290 HELP WAN	4333	
4291	PROMOTIONAL ADVERTISING	769		20	3	25	-769		4291	4291 PROMOTIO	769	
4292	PUBLIC RELATIONS	4569		20	3	25	-4569		4292	4292 PUBLIC RE	4,569	
4300	LICENSES & FEES	37175		20	3	17	0		4300	4300 LICENSE &	37,175	
4310	DUES & SUBSCRIPTIONS	5702		20	3	17	0		4310	4310 DUES & SU	5,702	
4320	CONTRIBUTIONS	0		27	3	20	0		4320			
4350	PROFESSIONAL FEES	12769	108769	19	3	22	-75		4350	4350 PROFESSIO	12,769	
4355	MEDICAL DIRECTOR	9000	9000	9	3	0	0		4355	4355 MEDICAL D	9,000	
4360	UTILIZATION REVIEW	0		10	3	0	0		4362	4362 MEDICAL R	300	
4361	OTHER PHYSICIAN FEES	0		39	3	0	0		4363			
4362	MEDICAL RECORDS CONSULT	300		10	3	0	0		4364			
4363	PHARMACIST FEES	0		10	3	0	0		4370	4370 TV RENTAL	812	
4364	SOC SERV/ACT CONSULT	0	0	12	3	0	0		4383	4383 BACKGROU	330	
4370	TV RENTAL	812		35	3	5	-812		4390			
4380	INCOME TAXES		0	27	3	26	0		4400	4400 PAYROLL T	110,419	
4383	BACKGROUND CHECKS	330		20	3	26	0		4401	4401 PAYROLL T	5,928	
4400	PAYROLL TAXES	110419		22	3	0	0		4410	4410 GROUP INS	83,462	
4401	PAYROLL TAXES ADMINIST	5928		22	3	0	0		4420	4420 LIABILITY	48,606	
4410	GROUP INSURANCE	83462		22	3	0	0		4430	4430 WORKMAN	25,339	
4420	LIABILITY INSURANCE	48606	48606	26	3	0	0		4435			
4425	INSURANCE-OWNERS			22	3	21	0		4436			
4430	WORKMENS COMP INSURANCE	25339		22	3	0	0		4450	4450 MANAGEM	96,000	
4450	CENTRAL OFFICE FEES	96000		19	3	34	0		4460			
4460	BAD DEBTS	0		27	3	24	0		4461			
4470	LOST ITEMS-RESIDENTS	0		27	3	0			4470			
4490	MISCELLANEOUS			27	3	0	0		4475	4475 UNIFORM	(822)	
4510	REAL ESTATE TAXES	0	0	33	3	0	0		4486	4486 SERVICE C	4,901	
4600	LEASED EQUIPMENT	825	1637	35	3	16	0		4490	4490 MISC EXPE	48	
5110	MAINTENANCE SALARIES	54827	58115	6	1	0	0		4496	4496 MISC. M.I.S	2,374	
5120	MAINTENANCE SICK & VAC	3288		6	1	0	0		4510			
5130	ELECTRIC	36010	56941	5	3	0	0		4600	4600 LEASED EQ	825	
5131	NATURAL GAS	15376		5	3	0	0		5110	5110 MAINTENA	54,827	
5132	HEATING & DEISEL OIL			5	3	0	0		5120	5120 MAINTENA	3,288	
5133	WATER & SEWER	5555		5	3	0	0		5130	5130 ELECTRIC	36,010	
5134	TRASH COLLECTION	2636	24060	6	3	0	0		5131	5131 NATURAL	15,376	
5140	PROPERTY PLANT REPLACEMNT	2239	25690	6	2	0	0		5133	5133 WATER & S	5,555	
5160	GENERAL REPAIR & MAINT	23451		6	2	0	0		5134	5134 TRASH CO	2,636	
5165	MAINTENANCE CONTRACTS	21424		6	3	0	0		5140	5140 PROP/PLAN	2,239	
5210	DIETARY WAGES	169679	178749	1	1	0	0		5160	5160 GENERAL R	23,451	
5220	DIETARY SICK & VAC	9070		1	1	0	0		5165	5165 MAINTENA	16,523	
5240	SALES TAX			2	3	13	-620		5210	5210 DIETARY W	169,679	
5248	FOOD PURCHASES	124031	117047	2	2	0	0		5220	5220 DIETARY P	9,070	
5250	SUPPLIES-DISHWASHING	4171	11855	1	2	0	0		5248	5248 FOOD PUR	123,983	
5260	DIETARY REPLACEMENT	2412		1	2	0	0		5250	5250 SUPPLIES D	4,171	
5270	KITCHEN SUPPLIES-PAPER	5272		1	2	0	0		5260	5260 REPLACEM	2,412	
5295	MEAL CREDIT	-6984		2	2	0	0		5270	5270 KITCHEN S	5,272	
5310	LAUNDRY WAGES	32312	33652	4	1	0	0		5295	5295 MEAL INCO	(6,984)	
5340	LAUNDRY SICK & VAC	1340		4	1	0	0		5310	5310 LAUNDRY	32312	
5370	LAUNDRY REPLACEMENT	1676	6105	4	2	0	0		5340	5340 LAUNDRY	1,340	
5380	LAUNDRY REIMBURSEMENT	0		4	3	0	0		5370	5370 REPLACEM	1,676	
5390	LAUNDRY SUPPLIES	4429		4	2	0	0		5380	5380 OUTSIDE L	257	
5410	HOUSEKEEPING WAGES	51293	54613	3	1	0	0		5390	5390 SUPPLIES	4,172	
5440	HOUSEKEEPING SICK & VAC	3320		3	1	0	0		5410	5410 HOUSEKEE	51,293	
5480	HOUSEKEEPING SUPPLIES	4318	14599	3	2	0	0		5440	5440 HOUSEKEE	3320	
5490	HOUSEKEEPING SUPPLIES-PPR	10281		3	2	0	0		5480	5480 SUPPLIES-C	4,318	
6010	RN WAGES-MEDICARE		968498	10	1	0	0		5490	5490 SUPPLIES-P	10,281	
6020	RN WAGES-NON MEDICARE	263469		10	1	0	0		6020	6020 RN WAGES	263,469	
6030	DON WAGES	49427		10	1	0	0		6030	6030 DON WAGE	49,427	
6035	ADON	0		10	1	0	0		6035			
6040	RN SICK & VACATION	17512		10	1	0	0		6040	6040 RN PTO &	17,512	
6110	LPN WAGES-MEDICARE			10	1	0	0		6120	6120 LPN WAGE	159,155	
6120	LPN WAGES-NON MEDICARE	159155		10	1	0	0		6140	6140 LPN PTO &	8,581	
6130	LPN WAGES OTHER			10	1	0	0		6220	6220 AIDES WAG	375,505	
6140	LPN SICK & VACATION	8581		10	1	0	0		6240	6240 AIDES PTO	33,382	
6210	AIDE WAGES-MEDICARE			10	1	0	0		6245			
6220	AIDE WAGES-NON MEDICARE	375505		10	1	0	0		6246			
6230	WARD CLERKS			10	1	0	0		6247	6247 CONTRACT	13638	
6240	AIDE VACATION & SICK	33382		10	1	0	0		6250			
6245	CONTRACT NURSES-RN	0		10	3	0	0		6255			
6246	CONTRACT NURSES-LPN	0		10	3	0	0		6260	6260 NURSE AID	(450)	
6247	CONTRACT NURSES-AIDES	13638		10	3	0	0		6270	6270 REHAB WA	55,368	
6250	NURSE AIDE TRAINING WAGES	0	0	13	1	0	0		6275	6275 REHAB PTO	6,099	
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0		6290	6290 NURSING S	50,140	
6260	NURSE AIDE TRAINING REIMB	-450		0	0	0	0		6295	6295 NURSING S	12,632	
6270	REHAB WAGES	55368		10	1	0	0		6390	6390 REPLACEM	362	
6275	REHAB SICK & VAC	6099		10	1	0	0		6490	6490 OTHER	840	
6280	NURSING DEPT EDUCATION			23	3	0	0		7280	7280 DRUG PUR	34,792	
6290	NURSING SUPPLIES	50140	63134	10	2	0	0		7281			
6295	NURSING SUPPLIES	12632		10	2	0	0		7380	7380 LABORATO	4,168	
6390	REPLACEMENT-NURSING	362		10	2	0	0		7391			
6490	NURSING OTHER	840	14778	10	3	0	0		7393			
7280	DRUG PURCHASES	34792	35487	39	2	0	0	***	7510	7510 ACTIVITIE	38666	
7281	DRUG PURCHASES-OTHER	0		39	2				7540	7540 ACTIVITIE	1,802	
7380	LABORATORY SERVICES	4168	83347	39	3	0	0		7590	7590 ACTIVITIE	1183	
7410	HOME HEALTH SALARY			39	1	0	0		7620	7620 PHYSICAL	46565	
7440	HOME HEALTH SICK & VAC			39	1	0	0		7660	7660 P.T. SUPPL	695	
7450	HOME HEALTH EXPENSES			39	3	0	0		7710	7710 SOCIAL SE	20014	
7510	ACTIVITES WAGES	38666	40468	11	1	0	0		7720			
7540	ACTIVITIES SICK & VAC	1802		11	1	0	0		7730	7730 SOCIAL SE	42	
7590	ACTIVITIES SUPPLIES	1183	1183	11	2	0	0		7740	7740 OCCUPATI	26,209	
7595	ACTIVITIES FEES	1480	1480	11	3	0	0		7750	7750 SOCIAL CO	1367	
7610	PT WAGES			39	1	0	0		7770	7770 SPEECH TH	6405	
7611	PT SICK & VACATION			39	1	0	0		7820	7820 BEAUTICIA	11741	
7620	PT FEES	46565		39	3	0	0	***	7890	7890 BEAUTY SH	696	
7660	PT SUPPLIES	695		39	2	0	0		7960			
7710	SOCIAL SERVICE WAGES	20014	20014	12	1	0	0		8120	8120 INTEREST	278	
7720	SOCIAL SERVICE SICK & VAC	0		12	1	0	0		8125			
7730	SOCIAL SERVICE EXPENSES	42	42	12	2	0	0		8130	8130 DEPRECIAT	109038	
7740	OT FEE	26209		39	3	0	0	***	8150			
7750	SOCIAL THERAPIST FEE	1367	1367	12	3	0	0		9510	9510 INTEREST I	-10446	
7770	SPEECH THERAPY FEE	6405		39	3	0	0	***	9520	9520 MISC NON-	-5626	
7800	BEAUTICIAN WAGES	0	0	40	1	0	0		9530	4361 OTHER PHYSICIAN FEES		
7810	BEAUTICIAN SICK & VAC			40	1	0	0			4360 UTILIZATION REVIEW		
7820	BEAUTICIAN FEES	11741	11741	40	3	0	0			7800 BEAUTICIAN WAGES		
7890	BEAUTY SHOP SUPPLIES	696	696	40	2	0	0			7595 ACTIVITIE	1,480	
7910	VOLUNTEER COORDINATOR	0		21	1	0	0				(168,552)	
7940	VOL COORD SICK & VAC			21	1	0	0					
7960	VOL COORD SUPPLIES	0		21	2	0	0					
8100	RENT	0	0	34	3	0	0					
8120	INTEREST EXPENSE	278	278	32	3	14	-278					
8130	DEPRECIATION	109038	109038	30	3	9	-1060					
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	36135				
9510	INTEREST INCOME	-10446		32	0	10	0					
9520	MISC NON-OPERATING INCOME	-5626		0	0	0	0					
9700	INCOME TAXES	0		0	0	0	0					
		2572088	2588610									
			16522									
GRAND TOTALS		-168552					-12056					
		(NET INCOME)										
		0										

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0
168552

-337104